**Intake Form**

Name:

Address:

Date of Birth:

Telephone no. (home): (mobile/ work):

Email:

Occupation:

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP’s Name:

Address:

Other healthcare provider name:

Contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give my consent for my notes to be shared with the above: yes no

Main issues/ focus for treatment:

Have you ever had a major operation? If so please give details:

Are you currently taking any medication? If so please give details:

Do you or have you ever suffered from any of the conditions below?

Epilepsy Asthma Diabetes

Migraines Heart condition Joint problems

Spinal or other fractures Osteoporosis Cancer

Bladder problems Skin conditions Other

Please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant, or have you been pregnant within the past year? yes no

With acupuncture treatment there is a very small risk of fainting, and some small bruising may occur. Stretching sessions may lead to some muscle soreness for a few days after treatment.

If you are happy that all the information above is correct, and you understand the potential risks, please sign and date below, thank you.

SIGNED: DATE: